STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	LDING	00	COMPL	ETED
		155697	B. WIN			08/09/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION	AND SKILLED NURSING CENTER	!		SVILLE, IN 47129		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was for	or Investigation of	F00	00	This provider respectfully		
	Complaint IN00	0113180.			requests that the 2567 plan of		
					correction be considered the	_1	
	Complaint INOC	0113180 - Substantiated.			letter of credible allegation and requests a desk review on or	נ	
		ficiencies related to the			after August 20, 2012.		
					alter August 20, 2012.		
	_	eited at F309, F425, and					
	F514.						
	Survey dates: A	August 8 and 9, 2012					
	Facility number	: 000059					
	Provider numbe						
	AIM number: 1						
	Alivi liullibei. I	.00200300					
	Survey team: Jo	ennie Bartelt, RN					
	Census bed type	2.					
	SNF: 3						
	SNF/NF: 65						
	Total: 68						
	Canque novor to	me:					
	Census payor ty	pc.					
	Medicare: 7						
	Medicaid: 47						
	Other: 14						
	Total: 68						
	Sample: 3						
	These deficience	ies reflect state findings					
		nce with 410 IAC 16.2.					
	cited in accorda	nce with 410 IAC 16.2.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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0UXR11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMI	COMPLETED 08/09/2012	
	PROVIDER OR SUPPLIER	L ND SKILLED NURSING CENTER	STREET A 517 N L	ADDRESS, CITY, STATE, ZIP C LITTLE LEAGUE BLVD SVILLE, IN 47129	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ompleted 8/10/12	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	Cathy Emswiller						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0UXR11

Facility ID: 000059

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155697	B. WIN			08/09/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L		l	LITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0309 SS=D	483.25 PROVIDE CARE WELL BEING Each resident m must provide the services to attair practicable phys psychosocial we the comprehensicare. Based on record facility failed to assessed upon de from overnight le deficient practice reviewed related sample of 3. (Re Findings include During interview Resident C indic leave of absence week-end. Reside on a Friday and re The Resident Sig Station was revie p.m. The Out on indicated Reside on 7/20/12. Line	ust receive and the facility encessary care and or maintain the highest ical, mental, and II-being, in accordance with ive assessment and plan of review and interview, the ensure residents were eparture and/or return eave of absence. The eaffected 2 of 3 residents to leave of absence in a esidents C and A) : on 8/8/12 at 4:35 p.m., ated she recently went on to visit family for a long dent C indicated she left returned on Monday. gn-Out Log at the Nurses ewed on 8/8/12 at 3:55 in Pass form in the log and C left for a home visit es for the time of 0/12 and date and time of 0/12 and date and time of	F03		What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice? Resid C had no negative outcomes related to LOA Resident A ho negative outcome related to LOAHow other residents having the potential to be affected by same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to affected by the alleged deficient practice. Licensed nursing significant will be in serviced 8/14/12 by DNS/Designee on resident lead of absence policy and procedures. DNS/Designee implemented on 8/20/12 a resident leave of absence form that must be used on each resident going on LOAs. Documentation to include date and time resident left, method transportation, assessment of resident, all meds sent including the number sent, and administration instructions for each med. The responsible pages.	be nts y lent ad o ng the nt taff we of ng	08/20/2012
	1. The clinical reviewed on 8/8/	ecord for Resident C was			will sign the LOA form indicati understanding of instructions.	-	

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Event ID: 0UXR11

Facility ID: 000059

If continuation sheet Page 3 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 00 COMPLETED . BUILDING 155697 08/09/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 517 N LITTLE LEAGUE BLVD CLARK REHABILITATION AND SKILLED NURSING CENTER CLARKSVILLE. IN 47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Upon return documentation in the nurses notes will include date and Physician's orders for July 2012 included, time returned, who accompanied but were not limited to, "May take leave resident, meds returned and how of absence with responsible party and many, and physical assessment meds [medications]." of resident. · Two nurses will validate meds being sent with resident going LOA and both to Resident Progress Notes indicated: sign the LOA form. · All residents that go on leave of absence 7/20/12 at 6:00 p.m., "Res [resident] left documentation will be reviewed upon leaving and return by the with family at 2:30 p.m. this date to go DNS/Designee. · Daily LOA [leave of absence] for weekend, res DNS/Designee will review the is scheduled to return Monday morning leave of absence form for 7/23/12. All necessary meds sent with res timeliness and completion on all residents that go LOA. and given to res daughter, daughter agrees DNS/Designee is responsible to to monitor res medications for the ensure compliance. · weekend, res has no open areas on skin, Non-compliance will result in further education including res alert and oriented X 3. Personal disciplinary actions. What belongings secured in room." measures will be put into place or what systematic changes will be 7/22/12 at 2:48 a.m., "No S/S [signs and made to ensure that the deficient symptoms] dehydration noted call light in practice does not recur? · Licensed nursing staff will be in reach." serviced 8/14/12 by DNS/Designee on resident leave 7/24/12 at 4:48 a.m., "No s/s of of absence policy and dehydration noted with good skin turgor, procedures. · DNS/Designee implemented on 8/20/12 a encouraged po [by mouth] fluids this shift resident leave of absence form and taken well. Will continue to monitor that must be used on each closely." resident going on LOAs. Documentation to include date and time resident left, method of Documentation in the Matrix system for transportation, assessment of Resident Progress Notes, Events, and resident, all meds sent including Observations failed to indicate when the the number sent, and resident returned to the facility or any administration instructions for

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assessment of the resident upon return

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Facility ID: 000059

If continuation sheet

each med. The responsible party

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	TED
		155697	B. WING			08/09/2	012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	2		SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG			DATE
	from leave of ab	sence.			will sign the LOA form indicati	ng	
					understanding of instructions.	41	
	During interview on 8/9/12 at 10:35 a.m.,				Upon return documentation in nurses notes will include date		
	_	fursing (DON) and			time returned, who accompani		
		or of Nursing (ADON)			resident, meds returned and h		
		ord did not indicate when			many, and physical assessme		
					of resident. · Two nurses will		
		rned from leave of			validate meds being sent with		
		information, including			resident going LOA and both t		
	assessment of the	e resident upon return.			sign the LOA form. · All reside	ents	
					that go on leave of absence		
	2. The Resident	Sign-Out Log was			documentation will be reviewe		
	reviewed at the N	Nurses Station on 8/8/12			upon leaving and return by the DNS/Designee. Daily	, l	
		Out on Pass form in the			DNS/Designee will review the		
	_	sident A left on 5/6/12 at			leave of absence form for		
	_				timeliness and completion on	all	
	_	turned on 5/7/12 at 8:00			residents that go LOA.		
	_	5/16/12 at 10:00 p.m.			DNS/Designee is responsible	to	
	and returned on :	5/17/12 at 10:00 p.m.			ensure compliance.		
					Non-compliance will result in		
	The clinical reco	rd for Resident A was			further education including disciplinary actions. How the		
	reviewed on 8/8/	12 at 5:25 p.m.			corrective action will be monitor	ored	
		•			to ensure the deficient practice		
	Resident Progres	s Notes included an entry			will not recur, i.e., what quality		
		next entry in the Notes			assurance program will be put		
		-			into place? The CQI audit or		
		:15 p.m., and indicated,			resident leave of absence will		
		om LOA with family			utilized weekly x 4, bi-weekly x		
	l •	rake, not distress noted,			months, monthly x3, and quart thereafter for 2 consecutive	lerry	
	accu check [bloo	d sugar monitoring] 142			quarters. · Findings from the	col	
	upon return, rout	ine meds given, res			process will be review monthly		
	appears to be con	nfortable and in no			and an action plan will be		
		thter stated res enjoyed			implemented for thresholds be	low	
	visit."	,			95%.		
	, 101t.						
	Dogidant Dasser	ng Notes for 5/16/12 -4					
	1	s Notes for 5/16/12 at					
	I 10:45 p.m., indic	ated, "Res on LOA with					

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Event ID: 0UXR11

Facility ID: 000059

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697		(X2) MUI A. BUILD B. WING	DING	NSTRUCTION 00	(X3) DATE (COMPL 08/09/	ETED	
			B. WING	_	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	R			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	₹	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		rnight visit, to return tom		TAU	BEHELENETY		DATE
	_	t. LOA meds sent with					
	1 2	tocol." The next					
		ss Note was dated					
	5/23/12.						
	Documentation i	n Resident Progress					
	Notes, Events, an	nd Observations failed to					
	indicate other in	formation related to the					
		before and after the					
	leaves of absence.						
	During interview	on 8/8/12 at 5:35 p.m.,					
		er researched in the					
	_	tation system and					
	indicated he was	•					
		ted to assessments of the					
		ates of the leaves of					
	absence, other th	an those indicated in the					
	Resident Progres	ss Notes.					
	TI 6 11: 1						
		licy related to Resident					
		trator on 8/9/12 at 10:00					
		trator on 8/9/12 at 10:00 the policy indicated, "It is					
		facility that continuity of					
		ent Leave of Absence					
	_	Procedure:The					
	_	POA [power of attorney]					
		dent in and out of the					
	1	eave of Absence form.					
	1	se will document resident					
	status upon leave	e from the facility and					
	upon return from	leave, and any other					

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Event ID: 0UXR11

Facility ID: 000059

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV OO COMPLETEI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
		155697	B. WIN			08/09/	ZU Z
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
CLARK F	REHARII ITATION A	AND SKILLED NURSING CENTER	,		ITTLE LEAGUE BLVD SVILLE, IN 47129		
		TATEMENT OF DEFICIENCIES	<u> </u>	<u> </u>			(7/5)
(X4) ID PREFIX		ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	pertinent inform	ationDocumentation:					
	Nursing notes when resident leaves						
	_	clude: Date and time					
		lity; Medications					
		with whom the resident is					
	-	pected time and date of					
		physical assessment of					
		nethod of transportation;					
		with the resident; Any					
		nformation relative to the					
	•	ve of absence. Nursing					
		ent return are to include:					
	-	Party with whom the					
	•	l; Overall physical					
		e resident; Mode/method					
		; Equipment returned					
	-	; Medications/treatment					
		d with the resident,					
	* *	ty; Any other pertinent					
	~ .	tive to the resident and					
	leave of absence						
	This federal tag	relates to Complaint					
	IN00113180.						
	3.1-37(a)						
	` /						
			1				

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Event ID: 0UXR11

Facility ID: 000059

 $\label{eq:local_problem} \mbox{If continuation sheet} \qquad \mbox{Page 7 of 20}$

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155697	B. WIN	G		08/09/	2012
	PROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER		517 N L	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0425 SS=D	PROCEDURES, The facility must emergency druggresidents, or obta agreement descripart. The facility personnel to administering the accurate acquand administering biologicals) to more resident. The facility must personnel to administering biologicals to more resident. The facility must personnel to administering biologicals to more resident. The facility must services of a lice provides consultantly provision of pharms. Based on intervite facility failed to a followed for disperson for residents on a capable of 3 residents reversed in the decorporation of the sample of 3 residents. Findings include During interview Resident C indications for	provide routine and s and biologicals to its ain them under an ribed in §483.75(h) of this may permit unlicensed minister drugs if State law under the general licensed nurse. Tovide pharmaceutical may procedures that assure quiring, receiving, dispensing, g of all drugs and eet the needs of each employ or obtain the ensed pharmacist who ation on all aspects of the macy services in the facility. The ensure policies were pensing pharmaceuticals overnight leave of ficient practice affected 2 viewed related to leave of absence in a dents. (Residents C and	F04	25	What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice? Reside C had no negative outcome related to LOA Resident A hono negative outcome related to the LOA How other residents having the potential to be affected by same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to affected by the alleged deficient practice. Licensed nursing significant will be in serviced 8/14/12 by DNS/Designee on resident lead of absence policy and procedures. DNS/Designee	nts y ent ad o ng the be nt taff	08/20/2012

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Event ID: 0UXR11

Facility ID: 000059

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		155697	B. WIN			08/09/2	2012
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	KOVIDEK OK SUPPLIER			517 N L	ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		lent C indicated she left		TAG	implemented on 8/20/12 a		DATE
					resident leave of absence forn	, l	
		returned on Monday.			that must be used on each		
	Resident C indicated she had a problem				resident going on LOAs.		
	with her medicat	ions, since not all of her			Documentation to include date		
	medications were	e sent with her, so she			and time resident left, method	of	
	had to return to t	he facility to straighten			transportation, assessment of		
		Resident C indicated her			resident, all meds sent includir the number sent, and	ng	
		e provided in envelopes			administration instructions for		
	that indicated the	-			each med. The responsible pa	irty	
		the time she should take			will sign the LOA form indicati		
		but after arriving at her			understanding of instructions.		
		•			Upon return documentation in		
	1	home, the family			nurses notes will include date		
		d the medications and			time returned, who accompani resident, meds returned and h		
		ere missing. Resident C			many, and physical assessme		
	indicated the fac	ility did not provide of			of resident. Two nurses will		
	list of the medica	ations with times the			validate meds being sent with		
	medications were	e to be taken, as the			resident going LOA and both t		
	facility had done	in the past.			sign the LOA form. · All reside	ents	
	Í	•			that go on leave of absence		
	During interview	on 8/8/12 at 5:45 p.m.,			documentation will be reviewe		
	_	porate Nurse Consultant			upon leaving and return by the DNS/Designee. Daily	, I	
					DNS/Designee will review the		
	indicated the fac	-			leave of absence form for		
	·	ystem did not include a			timeliness and completion on a	all	
		n list with instructions to			residents that go LOA. ·		
		esidents who go on leave			DNS/Designee is responsible	to	
	of absence, but the	he system did have the			ensure compliance.		
	home medication	n list with instructions for			Non-compliance will result in further education including		
	resident upon dis	scharge. During			disciplinary actions. What		
	_	same time, the Unit			measures will be put into place	e or	
		ed when a resident goes			what systematic changes will t	ре	
	_ ~	nce, the facility places the			made to ensure that the defici	ent	
		ations in envelopes with			practice does not recur?		
		*			Licensed nursing staff will be i	n	
		ten on the envelope on			serviced 8/14/12 by DNS/Designee on resident lea	I	
	how to take the r	nedications. He			DINO/Designee on resident lea	IVC	

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Event ID: 0UXR11

Facility ID: 000059

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLETED	
		155697	A. BUII B. WIN			08/09/2012	
			b. WIIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ITTLE LEAGUE BLVD		
CLVDKE		AND SKILLED NURSING CENTER			SVILLE, IN 47129		
		AND SKILLED NORSING CENTER		CLARK	SVILLE, IN 47 129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(2	X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	LETION
TAG		LSC IDENTIFYING INFORMATION)		TAG		DA	.TE
	indicated the me	dications are discussed			of absence policy and		
	with the family.				procedures. · DNS/Designee implemented on 8/20/12 a		
					resident leave of absence form	,	
	During interview	v on 8/8/12 at 5:50 p.m.,			that must be used on each	'	
	_	inistrator provided copy			resident going on LOAs.		
		oolicy "15.0 Leave of			Documentation to include date		
		edications." The Interim			and time resident left, method	of	
					transportation, assessment of		
		dicated this was a policy			resident, all meds sent including	ng	
		facility's contracted			the number sent, and administration instructions for		
		ould be followed.			each med. The responsible pa	rtv	
	Review of the po	olicy indicated,			will sign the LOA form indicat		
	"Procedure: T	he physician must give an			understanding of instructions.		
	order indicating	the resident may take			Upon return documentation in	the	
	his/her medication	on with him/her while on			nurses notes will include date		
	LOA (leave of a	bsence). The order musts			time returned, who accompan		
	`	resident's clinical record.			resident, meds returned and h many, and physical assessme		
		d include: the name of			of resident. • Two nurses will		
		the number of doses to			validate meds being sent with		
	be released to th				resident going LOA and both t	0	
					sign the LOA form. · All reside	ents	
		sponsible party. The			that go on leave of absence		
		ment in the resident's			documentation will be reviewe		
	clinical record th				upon leaving and return by the DNS/Designee. Daily		
	medications, nur	nber of tablets/capsules			DNS/Designee will review the		
	given, who the n	nedication was released			leave of absence form for		
	to, and what dire	ections were given			timeliness and completion on	all	
	regarding he me	C			residents that go LOA.		
	" "	PRN [as needed] ordered			DNS/Designee is responsible	to	
					ensure compliance.		
	medication, the directions should include the symptoms for which the medication is to be administered. The nurse will give the resident/POA/responsible party written directions regarding the				Non-compliance will result in further education including		
					disciplinary actions. How the		
					corrective action will be monitor	ored	
					to ensure the deficient practice		
					will not recur, i.e., what quality		
		opy of the instruction			assurance program will be put		
	will be placed in	the resident's clinical			into place? · The CQI audit or	1	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		155697	B. WIN			08/09/2	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L.			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· ·	become a permanent part			resident leave of absence will		
	of the resident's	clinical record.			utilized weekly x 4, bi-weekly x 2 months, monthly x3, and quarter		
	Medication brou	ght back from a LOA			thereafter for 2 consecutive	City	
	will be documen	ted in the resident's			quarters. Findings from the (CQI	
	clinical record, the	he documentation will			process will be review monthly		
	include the name	e of the medication, the			and an action plan will be		
		r of tablets/capsules			implemented for thresholds be 95%.	low	
	returned, and wh	•			3J /0.		
	•	there is a facility policy in	1				
		LOA medications, the					
	1	ill supersede this policy.					
	lacinty poney w	in supersede uns poney.					
	During interview	on 8/9/12 at 9:35 a.m.,					
	_	inistrator showed a form					
		to document medication					
		ve of absence. She					
	_	m is no longer used, since					
		different pharmacy					
		terim Administrator also					
	_	d checked with sister					
		ers in the American					
		ities corporation do not					
		entation for medications					
		nce. The Interim					
		dicated an American					
		ities policy would					
	_	cy of the company's					
		the contracted pharmacy.	1				
	_	lated to leave of absence					
1	medications were	e requested.					
l	The facility's pol	icy related to Resident					
İ	Leave of Absence	e was provided by the					
	Interim Adminis	trator on 8/9/12 at 10:00					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155697	B. WIN	G		08/09/	2012
NAME OF F	PROVIDER OR SUPPLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	NO VIDER OR SOIT EIE				ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTE	R	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		the policy indicated, "It is					
	the policy of this facility that continuity of care during resident Leave of Absence						
	_	The licensed nurse					
		esident status upon leave					
		and upon return from					
		ntation:Nursing notes					
		aves facility are to					
	include:medi						
	_	ng notes upon resident					
	return are to incl	ude:					
	Medications/trea	atment supplies returned					
	with the resident	t, including quantity"					
	Further informat	tion related to					
	medications on l	eave of absence was not					
	indicated in the p	policy.					
	1. The clinical r	record for Resident C was					
	reviewed on 8/8/	/12 at 3:55 p.m.					
	Physician's order	rs for July 2012 included,					
	but were not lim	ited to, "May take leave					
	of absence with	responsible party and					
	meds [medicatio	ons]."					
	Resident Progres	ss Notes indicated:					
	7/20/12 at 6:00 p	o.m., "Res [resident] left					
	with family at 2:30 p.m. this date to go						
	LOA [leave of a	bsence] for weekend, res					
	is scheduled to r	eturn Monday morning					
		cessary meds sent with res					
		daughter, daughter agrees					
	_	nedications for the					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	LDING	00	COMPI	ETED
		155697	B. WIN			08/09	/2012
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
NAME OF P	ROVIDER OR SUPPLIER			517 N L	ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER	₹	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		s no open areas on skin,					
		ented X 3. Personal					
	belongings secur	red in room."					
	Documentation i	in the hard copy of the					
		nd in the Matrix system					
		mation failed to indicate					
	_	tion related to the					
	. ^	ations at the time of leave					
	of absence.						
	or deserve.						
	During interview	v on 8/9/12 at 10:35 a.m.,					
	the Director of N	Nursing (DON) and					
		or of Nursing (ADON)					
		ord did not indicate the					
		•					
	returned to the it	ucinty.					
	On 8/9/12 at 12:	40 p.m., the DON and					
	ADON were into	erviewed. The DON					
	indicated the res	ident left for leave of					
	absence in the at	fternoon, and didn't get					
		topped to get something					
	_						
	_						
		_					
	resident when the started, or informedications returned to the farmed to the farmed to the farmed to the farmed to the result absence in the affar, as she had sto eat, when the there was a probes of she returned to the returned to the second to the secon	40 p.m., the DON and erviewed. The DON ident left for leave of fternoon, and didn't get copped to get something resident's family realized lem with the medications, to the facility. She cond shift nurse's indicated the resident left the first or second shift					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NU		IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED
155697		B. WIN			08/09/	2012	
NAME OF BROWINGS OF GUIDNI IED				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				517 N L	ITTLE LEAGUE BLVD		
CLARK REHABILITATION AND SKILLED NURSING CENTER			₹	CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	BLI ICILIACI)		DATE
	shift change. The DON and ADON						
		ord did not indicate what					
		e provided to the resident					
		second time the					
ı	medications wer	e dispensed.					
	During interview	v on 8/9/12 at 1:30 p.m.,					
	_	ed Resident C went on					
		when LPN #15 was on					
		t. She indicated she and					
	another nurse, LPN #19, who was being						
	oriented to the facility, prepared the						
	medications for the resident's leave of						
	absence. LPN #15 indicated the medications were packaged into						
	envelopes with it						
	_	n the envelopes. LPN					
		ter the resident left, when					
		, , , , , , , , , , , , , , , , , , ,					
		oming nurse, LPN #25,					
		the narcotic count at					
	_	e realized there was a					
	_	e medications that had					
		For the leave of absence.					
		ed they were "three pills					
		resident's [medication]					
	card." LPN #15 indicated Resident C						
		ome with three of the					
	other resident's Ativan (antianxiety						
	1	tead of Resident C's					
	Ambien (sleep medication). LPN #15 indicated she reported the problem to the						
	DON and ADON	N. She indicated the					
	family was phon	ed at home, and the					
	resident and a family member returned						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING X3) DATE SURVEY COMPLETED 08/09/2012				ETED	
	PROVIDER OR SUPPLIEI	R AND SKILLED NURSING CENTER	517	'NL	.DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		ad left the facility. LPN PN #25 dispensed the ations.					
	Nurse's Station of 3:55 p.m. The Clog indicated Re 9:00 p.m. and rep.m., and left on and returned on The clinical recorreviewed on 8/8/ Resident Progres on 5/2/12. The rewas 5/7/12 at 10 "Res returned from present, alert, avaccu check [blood upon return, rour appears to be condistress, resident Progres 10:45 p.m., indicated the condition of th	Sign-Out Log at the was reviewed on 8/8/12 at Out on Pass form in the sident A left on 5/6/12 at turned on 5/7/12 at 8:00 5/16/12 at 10:00 p.m. 5/17/12 at 10:00 p.m. 5/17/12 at 10:00 p.m. ord for Resident A was /12 at 5:25 p.m. Sign Notes included an entry mext entry in the Notes 1:15 p.m., and indicated, om LOA with family wake, not distress noted, od sugar monitoring] 142 tine meds given, resimfortable and in no ghter stated res enjoyed Sign Notes for 5/16/12 at cated, "Res on LOA with emight visit, to return tom it. LOA meds sent with stocol." The next is solve was dated					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2012 FORM APPROVED OMB NO. 0938-0391

155607		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED 08/09/2012
	PROVIDER OR SUPPLIER REHABILITATION AND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN 47129	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Documentation in the hard copy of the resident's clinical record, and in Resident Progress Notes, Events, and Observations in the Matrix system failed to indicate other information related to the resident's medications during leave of absence. During interview on 8/8/12 at 12:40 p.m., the Director of Nursing and Assistant Director of Nursing indicated there was no other information about medications sent with the resident and returned by the resident for the leaves of absence. This federal tag relates to Complaint IN00113180. 3.1-25(e)(3)			

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STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BUILDING 00			COMPLETED	
155697		A. BUILDING B. WING 08/09/2012			2012		
			B. WIN		ADDRESS OF STATE ZID CODE		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
CLARK REHABILITATION AND SKILLED NURSING CENTER				517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129			
CLARK R	KEHABILITATION A	AND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTIO		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE
F0514	483.75(I)(1)						
SS=D	RES						
	RECORDS-COMPLETE/ACCURATE/ACCE						
	SSIBLE						
	-	maintain clinical records on					
		accordance with accepted					
		ndards and practices that are					
		ately documented; readily					
	accessible; and	systematically organized.					
	The clinical reco	rd must contain sufficient					
		entify the resident; a record					
		assessments; the plan of					
	care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure the clinical record was accurate when the resident was on						
			F05	14	What corrective action(s) will be accomplished for those residents		08/20/2012
					•	found to have been affected by the	
					deficient practice?		
	leave of absence	for 1 of 3 residents					
	reviewed related	to accuracy of the			· Resident C continues to		
	clinical record in	a sample of 3. (Resident			receive treatments as indicated by		
	C)	•			physician orders while in the		
					building.		
	Findings in stude				How other residents having the		
	Findings include	·-			potential to be affected by the sar	same ed	
					deficient practice will be identified		
	The clinical reco	ord for Resident C was			and what corrective actions will be		
	reviewed on 8/8/	'12 at 3:55 p.m.			taken?		
	Physician's order	rs for July 2012 included			· All residents have the potential		
	Physician's orders for July 2012 included, but were not limited to, "May take leave of absence with responsible party and meds [medications]."				to be affect by the alleged deficient		
					practice.		
					Licensed nursing staff will be a second of the second	эе	
					re-educated 8/14/12 by the		
					DNS/Designee on the documenta guidelines policy and procedure.	LIOI I	
	Resident Progres	ss Notes indicated:			Documentation must be accurate and complete.		
	7/20/12 at 6:00 ==	m "Dag [ragidant] laft			An audit of the treatment		
7/20/12 at 6:00 p.m., "Res [resident] left		1		records was completed on or by			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155697 08/09/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 517 N LITTLE LEAGUE BLVD CLARK REHABILITATION AND SKILLED NURSING CENTER CLARKSVILLE. IN 47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG 8/14/12 by DNS/Designee to ensure with family at 2:30 p.m. this date to go completion and accuracy. LOA [leave of absence] for weekend, res A pink laminated form alerting is scheduled to return Monday morning staff to residents LOA is now placed in front of the residents MAR and 7/23/12. All necessary meds sent with res TAR while resident is out of building and given to res daughter, daughter agrees Two nurses will validate meds to monitor res medications for the being sent with resident going LOA and both to sign the LOA form weekend, res has no open areas on skin, Treatment records will be res alert and oriented X 3. Personal checked daily to ensure completion belongings secured in room." and accuracy by DNS/Designee. DNS/Designee is responsible to ensure compliance. 7/22/12 at 2:48 a.m., "No S/S [signs and Non-compliance will result in symptoms] dehydration noted call light in further education including disciplinary actions. reach." 7/24/12 at 4:48 a.m., "No s/s of What measures will be put into place or what systematic changes will be dehydration noted with good skin turgor, made to ensure that the deficient encouraged po [by mouth] fluids this shift practice does not recur? and taken well. Will continue to monitor closely." Licensed nursing staff will be re-educated 8/14/12 by the DNS/Designee on the documentation During interview on 8/9/12 at 12:40 p.m., guidelines policy and procedure. the Director of Nursing (DON) provided Documentation must be accurate and complete. Daily Census Reports for 7/22 and An audit of the treatment 7/23/12. Review of the reports indicated records was completed on or by Resident C was on "Therapeutic Leave" 8/14/12 by DNS/Designee to ensure completion and accuracy. on 7/22/12 and was "Readmit/Return" on A pink laminated form alerting 7/23/12. The DON indicated the resident staff to residents LOA is now placed returned on 7/23/12. in front of the residents MAR and TAR while resident is out of building Two nurses will validate meds The Medication Record for July 2012 being sent with resident going LOA indicated with a nurse's initials that the and both to sign the LOA form Treatment records will be resident's ordered medication, Lexapro checked daily to ensure completion (medication for depression or generalized and accuracy by DNS/Designee. anxiety disorder), was administered at DNS/Designee is responsible

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			URVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING COMPLETED			ETED			
155697		B. WIN			08/09/2	2012		
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF PROVIDER OR SUPPLIER					ITTLE LEAGUE BLVD			
CLARK REHABILITATION AND SKILLED NURSING CENTER			2		SVILLE, IN 47129			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
	9:00 a.m. on 7/2	22/12.			to ensure compliance.	in		
					Non-compliance will result further education including	further education including		
	The Treatment I	Record for July 2012			disciplinary actions.			
	indicated with n	urses' initials and check						
	marks that the fo	ollowing treatments were			How the corrective action will be			
		ordered on 7/21, 7/22,			monitored to ensure the deficient			
		ilateral knee high TED			practice will not recur, i.e., what			
		ytic deterrent) hose on in			quality assurance program will be	put		
	the morning and	*			into place?			
	_							
	-	cream, apply to			· The CQI audit tool on resid	lent		
		lly for itching - may self			leave of absence will be utilized			
	· ·	bath three times daily -			weekly x 4, bi-weekly x 2 months, monthly x3, and quarterly thereaf			
	may self administer; and Magic Butt, apply topically to sacrum 4 times daily until sore resolved - may keep at bedside.				for 2 consecutive quarters.			
					 Findings from the CQI prod 			
					will be review monthly and an act plan will be implemented for thresholds below 95%.	ion		
	_	w on 8/9/12 at 10:35 a.m.			threathered below 6676.			
		edication and treatments						
	when the reside	nt was on leave of						
	absence, the Ass	sistant Director of Nursing						
	(ADON) indica	ated she would write						
	"LOA," on the r	records, but since the						
	resident adminis	stered some of her own						
	treatments, may	be the nurses just signed						
	off.							
	During interview	w on 8/9/12 at 12:40 p.m.,						
	when interviewed about the Resident Progress Note for 7/22/12 when the resident was on leave of absence, the ADON raised her eyebrows and shook her							
· · · · · · · · · · · · · · · · · · ·								
	head, "No." This federal tag relates to Complaint							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING X3) DATE SURVEY COMPLETED 08/09/2012			
	PROVIDER OR SUPPLIEI	R AND SKILLED NURSING CENTEF	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN 47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	IN00113180.				
	3.1-50(a)(2)				

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